



# Center for the Study of Traumatic Stress Uniformed Services University School of Medicine

## Evidence-Based Management of Posttraumatic Stress Disorder (PTSD)

Posttraumatic Stress Disorder (PTSD) is characterized by symptoms of re-experiencing, avoidance/numbing, and hyperarousal persisting more than one month after exposure to a traumatic event or events. While not the only disorder seen after exposure to traumatic events, PTSD is among the most widely noted. The American Psychiatric Association and the U.S. Department of Veterans Affairs Office of Quality and Performance have published Practice Guidelines for the treatment of PTSD:

[http://www.psych.org/psych\\_pract/treatg/pg/PTSD-PG-PartsA-B-C-New.pdf](http://www.psych.org/psych_pract/treatg/pg/PTSD-PG-PartsA-B-C-New.pdf) and  
[http://www.oqp.med.va.gov/cpg/PTSD/PTSD\\_cpg/frameset.htm](http://www.oqp.med.va.gov/cpg/PTSD/PTSD_cpg/frameset.htm).

Practice guidelines do not define the standard of care. However, their synthesis of research and expert consensus augments clinical experience in treating patients, educating the public, guiding research, and establishing credibility for medical care delivery. Essential recommendations of the above noted PTSD Practice Guidelines are outlined below:

1. **Assessment**--Psychological effects of trauma may result from physical injury so detailed diagnostic evaluation should be continued after a physically and psychologically safe environment has been established, medical status has been stabilized, and psychological reassurance has been provided. Diagnostic evaluation may be accomplished through individual or group interviews or consultation. Surveillance instruments or screening symptom checklists may expedite the process. These may be helpful in identifying at-risk individuals for follow-up interview when large populations are exposed to trauma (e.g. natural disaster or terrorist event).
2. **Management**--Goals of management of patients with PTSD include establishment of a therapeutic alliance, providing ongoing assessment of safety and psychiatric status, addressing co-morbid disorders, and increasing the patient's understanding of, and coping with the effects of exposure to the traumatic event through the implementation of specific treatments (e.g. psycho-education, psychotherapy and/or pharmacotherapy) for PTSD.
3. **Psychotherapy**--Early supportive interventions including psycho-education and case management appear to facilitate entry into further evidence-based treatments. Cognitive Behavior Therapy (CBT) is effective treatment for core symptoms of PTSD. Studies have not yet clarified the critical element(s) of CBT but the element of controlled re-exposure to traumatic recollections is shared with other PTSD psychotherapies with demonstrated efficacy: prolonged exposure, EMDR, imagery rehearsal, and stress inoculation. Psychological debriefings or other single-session techniques in the immediate aftermath of trauma are ineffective in preventing the development PTSD.
4. **Pharmacologic Treatment**--Selective Serotonin Re-uptake Inhibitors are the first-line medication treatment for PTSD. Monoamine oxidase inhibitors and tricyclic antidepressants may also be beneficial. Benzodiazepines reduce anxiety and improve sleep but potential for dependence, withdrawal symptoms, and increased incidence of PTSD after early treatment with this medication class preclude recommendation as monotherapy. Anticonvulsants may be helpful adjuncts and second-generation antipsychotics may reduce symptoms in patients with co-morbid psychotic disorders.
5. **Combination psychotherapy/pharmacotherapy** although not well-studied, should be considered particularly if initial psychotherapy or medication therapy is ineffective.